CB
CAITLIN R. BURGESS, JD, MA, LMFT
Professional Clinical, Legal, and Forensic Services

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AGREEMENT FOR SERVICE / INFORMED CONSENT

Consent to Treat a Minor

The undersigned is the responsible parent or legal guardian and hereby authorizes Caitlin R. Burgess, JD, MA, LMFT, and her clinical associate(s) to provide counseling to the minor(s) stated below. The parent or legal guardian understands that while a therapy session is based on a 50-minute long hour, some young children benefit from shorter sessions. The parent or guardian further recognizes that the transportation to and from, and the supervision of the child (or children) before and after session, is the sole responsibility of the parent or guardian. Caitlin R. Burgess, JD, MA, LMFT, and her clinical associate(s) do not allow unaccompanied children (under the age of 12) in the waiting room without direct parental supervision. Clinical services are provided by Caitlin R. Burgess, JD, MA, LMFT, and her clinical associate(s), who are either currently licensed or who are in training to become licensed therapists. Clinicians who are in training are supervised by Caitlin R. Burgess (CA MFT #94485 and WA LF #61090853) on a weekly basis. During supervision meetings, your information may be discussed. All information shared between clinicians, supervisors and administration is handled confidentially within my practice.

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

The parents and/or guardians have agreed upon a fee for therapeutic services prior to the first session.

Parent's Name: ______________________________ Date: ____________

Child's Name: ______________________________ Date: ____________

Parent's Signature: ______________________________ Date: ____________

Therapist's Signature: ______________________________ Date: __________

CREDIT CARD AGREEMENT:

Please Note: New clients are requested to keep a valid credit card number on file. Please complete the following information and provide your credit card to your clinician at your initial session. This is set up for your convenience.

Credit Card Type: MasterCard Visa American Express Discover

Name as shown on card: ______________________________

Credit Card Number: ______________________________ Expiration date: ________

3-digit security code on back of the card: ______________________________

If American Express, 4-digit code on front of the card: ____________________

Billing Address associated with this credit/debit card:

____

Email Address: ______________________________

This card may be charged for:

- Regular session fees (at your request, as a convenience to you)
- Fees for same-day cancellation
- Fees for cancellation without 24-hour notice
- Delinquent session fees (fees more than 30 days overdue)
- Document review (including emails, Court records, and correspondence) (charged in three-minute increments)
- Phone calls over ten minutes (with clients and collateral contacts) (charged in three-minute increments)

Please enter the agreed upon fee for therapeutic services below:

The agreed-upon fee is $_______ per 50-minute clinical hour.

"I ______________________________ have read and understand the terms of providing my credit card to Caitlin R. Burgess, JD, MA, LMFT . I understand that my credit card may be charged for the reasons indicated above. I also understand there are

no refunds given. Any questions I have about this practice have been answered and I give my full consent to charge my credit card under the circumstances checked above."

Your Signature Consenting to Charges: ____

Today's date: ____________________

This credit card agreement is valid for one year beyond today's date or until termination of services.